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## Adult Self Report Form

*\*This form is completely confidential\**

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

*\*The following information on this form will help guide your treatment.  
Please try to fill out as much as you are comfortable disclosing.\**

Please briefly describe your presenting concern(s):

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Please check behaviors and symptoms that occur to you more often than you would like them to take place: List the onset and frequency of each checked behavior/symptom (i.e., 2 months ago, 3-4x wk)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aggression          | <input type="checkbox"/> Elevated mood              | <input type="checkbox"/> Phobias/fears                 |
| <input type="checkbox"/> Alcohol dependence  | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Recurring thoughts            |
| <input type="checkbox"/> Anger               | <input type="checkbox"/> Gambling                   | <input type="checkbox"/> Sexual addiction              |
| <input type="checkbox"/> Antisocial behavior | <input type="checkbox"/> Hallucinations             | <input type="checkbox"/> Sexual difficulties           |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Heart palpitations         | <input type="checkbox"/> Sick often                    |
| <input type="checkbox"/> Avoiding people     | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Sleeping problems             |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Hopelessness               | <input type="checkbox"/> Speech problems               |
| <input type="checkbox"/> Cyber addiction     | <input type="checkbox"/> Impulsivity                | <input type="checkbox"/> Suicidal thoughts             |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Irritability               | <input type="checkbox"/> Thoughts disorganized         |
| <input type="checkbox"/> Disorientation      | <input type="checkbox"/> Judgment errors            | <input type="checkbox"/> Trembling                     |
| <input type="checkbox"/> Distractibility     | <input type="checkbox"/> Loneliness                 | <input type="checkbox"/> Withdrawing                   |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Memory impairment          | <input type="checkbox"/> Worrying                      |
| <input type="checkbox"/> Drug dependence     | <input type="checkbox"/> Mood changes               | <input type="checkbox"/> Sleeping too much             |
| <input type="checkbox"/> Eating disorder     | <input type="checkbox"/> Headaches                  | <input type="checkbox"/> Feeling Manic                 |
| <input type="checkbox"/> Panic attacks       | <input type="checkbox"/> Nausea                     | <input type="checkbox"/> Abdominal Distress            |
| <input type="checkbox"/> Fainting            | <input type="checkbox"/> Sweating                   | <input type="checkbox"/> Shortness of Breath           |
| <input type="checkbox"/> Blackouts           | <input type="checkbox"/> Chills/Hot flashes         | <input type="checkbox"/> Severe Weight Gain/Loss       |
| <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Short Attention span       | <input type="checkbox"/> Pain in joints                |
| <input type="checkbox"/> Fidgeting           | <input type="checkbox"/> Difficulty with Finances   | <input type="checkbox"/> Difficulty with Relationships |
| <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Repetitive Behaviors       | <input type="checkbox"/> Muscle tension                |
| <input type="checkbox"/> Flashbacks          | <input type="checkbox"/> Difficulty trusting others | <input type="checkbox"/> Other _____                   |

Briefly discuss how the above symptoms impair your ability to function effectively:

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1. Are you having thoughts of hurting yourself or someone else? YES NO

**PAST TREATMENT**

2. Have you ever been treated for psychiatric, substance abuse, emotional, or behavioral problems in the past? Y N

If yes, when, where, and with whom? \_\_\_\_\_

3. Did you find past treatment helpful? YES NO

4. Previous psychiatric hospitalizations (Approximate dates and reasons):  
\_\_\_\_\_

5. Are you currently under the care of a psychiatrist, therapist, or your primary care provider for a psychiatric problems? YES NO

6. Are you currently taking any psychiatric medications? YES NO

If yes, please list name(s) and dosage(s): \_\_\_\_\_  
\_\_\_\_\_

7. Have you ever taken any psychiatric medications in the past that you are no longer taking? YES NO

If yes, please list name(s) and dosage(s): \_\_\_\_\_

**MEDICAL HISTORY:**

8. Please explain any significant medical problems, symptoms, or illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medications:**

Name of Medication	Dosage	Purpose	Name of Prescribing Doctor

9. When was the last time you were seen by a doctor? \_\_\_\_\_

10. Would you like information from today's visit communicated to your primary care provider or any other medical doctor? YES NO

11. Do you have a history of head injury, seizures or loss of consciousness? YES NO  
If yes, please explain: \_\_\_\_\_

12. (Women only) Are you pregnant? YES NO

13. Do you have pain management issues? YES NO

14. Previous medical hospitalizations (Approximate dates and reasons): \_\_\_\_\_  
\_\_\_\_\_

15. Do you smoke or use tobacco? YES NO If YES, how much per day? \_\_\_\_\_

16. Do you consume caffeine? YES NO If YES, how much per day? \_\_\_\_\_

**Substance Abuse**

17. Have you been treated for drug, alcohol abuse, or other addictions (food, gambling, sex, etc)? Y N

18. Do you currently attend support groups? YES NO If yes, please list: \_\_\_\_\_

19. Do you drink alcohol? YES NO If YES, how much per day/week/month/year? \_\_\_\_\_

20. Circle the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, methadone, LSD, PCP, ecstasy, inhalants.

21. Have you experienced withdrawal symptoms? YES NO If yes, circle all which apply: withdrawal, headaches, nausea, vomiting, tremors, seeing things, hearing things, other

22. Have you ever had a DUI? YES NO

23. Have any of your friends or family members voiced concern about your substance use? YES NO

24. Have you ever been in trouble or in risky situations because of your substance use? YES NO

**LEGAL ISSUES**

25. Do you have any current legal issues? YES NO If yes, please describe: \_\_\_\_\_

26. Are you currently on probation/parole? YES NO

27. Do you have a DFACS worker? YES NO

**FAMILY:**

**FAMILY/RELATIONSHIPS**

Relationship	Name	Age	Living		Living with you	
			Yes	No	Yes	No
Mother	_____	_____	___	___	___	___
Father	_____	_____	___	___	___	___
Spouse	_____	_____	___	___	___	___
Children	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
Siblings	_____	_____	___	___	___	___
	_____	_____	___	___	___	___
Other	_____	_____	___	___	___	___

28. Please list anyone not listed above who lives in your home, his/her age, and relationship: \_\_\_\_\_

**FAMILY HISTORY OF (Check all that apply):**

Drug/Alcohol Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Domestic Violence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Hospitalization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	“Nervous Breakdown”	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. How would you describe your relationship with your mother? \_\_\_\_\_  
\_\_\_\_\_

30. How would you describe your relationship with your father? \_\_\_\_\_  
\_\_\_\_\_

31. Are your parents still married? \_\_\_\_\_ If they divorced, how old were you when they separated or divorced, and how did this impact you? \_\_\_\_\_

32. Were there any other primary care givers who you had a significant relationship with? If so, please describe how this person may have impacted your life: \_\_\_\_\_  
\_\_\_\_\_

33. How would you describe your relationships with your siblings? \_\_\_\_\_  
\_\_\_\_\_

**RELATIONSHIPS & SOCIAL SUPPORT & SELF-CARE:**

**Marital Status** (more than one answer may apply)

Single     Divorce in process     Unmarried, living together  
Length of time: \_\_\_\_\_    Length of time: \_\_\_\_\_  
 Legally married     Separated     Divorced  
Length of time: \_\_\_\_\_    Length of time: \_\_\_\_\_    Length of time: \_\_\_\_\_  
 Widowed     Annulment  
Length of time: \_\_\_\_\_    Length of time: \_\_\_\_\_    Total number of marriages: \_\_\_\_\_  
Assessment of current relationship (if applicable): \_\_\_\_\_ Good     Fair     Poor

Current level of satisfaction with your friends and social support:    POOR    1 2 3 4 5 6 7 8 9 10    EXCELLENT

34. Please briefly describe your coping mechanisms and self-care: \_\_\_\_\_

35. Is spirituality important in your life and if so please explain: \_\_\_\_\_

35. How would you describe your diet and exercise patterns? Poor 1 2 3 4 5 6 7 8 9 10 (Excellent)

**EDUCATION & CAREER**

36. High School/GED \_\_\_\_\_ College Degree \_\_\_\_\_ Graduate Degree(or Higher) \_\_\_\_\_ Vocational Degree \_\_\_\_\_

37. Circle current employment status: full time, part time, unemployed, homemaker, student, disabled, retired

38. What is your current employment (if applicable)  
\_\_\_\_\_

POOR    EXCELLENT  
Employment Satisfaction: 1 2 3 4 5 6 7 8 9 10

39. Did you experience difficulties in school? YES NO. If yes, please list: \_\_\_\_\_

**OTHER AREAS OF CONCERN**

40. Do you have any history of abuse, neglect and/or trauma? Yes No.

41. What are your hobbies/interests?\_\_\_\_\_

42. Do you have any sexual orientation/gender issues or concerns? YES NO

43. Sexual Identity: Heterosexual\_\_ Lesbian\_\_ Gay\_\_ Bisexual\_\_ Transgender\_\_ In Question\_\_

44. Are you having difficulties with spiritual or religious matters? YES NO

45. Do you have difficulties or concerns about how you get along with other people? YES NO

46. Any additional information you would like to include:

\_\_\_\_\_  
\_\_\_\_\_

47. What are your goals for therapy? What would you like to see changed?

\_\_\_\_\_  
\_\_\_\_\_

Signature of Client (or person completing form) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Therapist \_\_\_\_\_ Date \_\_\_\_\_